STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
RHODE ISLAND DEPARTMENT OF HEALTH

NICOLE ALEXANDER-SCOTT, M.D., M.P.H.,
IN HER CAPACITY AS DIRECTOR OF THE
RHODE ISLAND DEPARTMENT OF HEALTH

IN THE MATTER OF:
ELEANOR SLATER HOSPITAL

COMPLIANCE ORDER

Now comes the Director of the Rhode Island Department of Health (hereinafter, the "Department") and, pursuant to R. I. Gen. Laws § 23-1-20, makes the following Findings and Order:

FINDINGS

1. Eleanor Slater Hospital (hereinafter, the "Hospital") is a hospital located on 111 Howard Avenue in the city of Cranston, which is licensed as a hospital by the Center of Health Facilities Regulation within the Department pursuant to R. I. Gen. Laws §§ 23-17-1 *et seq*.

2. Pursuant to R. I. Gen. Laws Chapter 23-17 and the Rules and Regulations for Licensing of Hospitals (R23-17-HOSP), and as a condition of its license, the Hospital is required to develop and implement patient care policies that ensure effective patient supervision and patient care.

3. On December 1, 2015, Department inspectors conducted an unannounced on-site inspection. The inspection identified that the Hospital failed to implement its patient care policies to ensure effective patient supervision. On January 22, 2016, the Hospital submitted a plan of correction to the Department alleging it had corrected the identified non-compliance.

4. On May 3, 2016, Department inspectors conducted an unannounced on-site inspection. The inspection included a follow-up review to validate that the Hospital had achieved and maintained compliance as indicated in its January 22, 2016 plan of correction. The inspection identified that the Hospital continued to be non-compliant with its patient care policies for providing effective patient supervision. As a result, on May 18, 2016, the Department issued a directed plan of correction to be implemented by the Hospital to achieve and maintain compliance.

5. On October 25, 2016, Department inspectors conducted an unannounced on-site inspection. The inspection included a follow-up review to validate that the directed plan of correction issued by the Department on May 18, 2016 was being implemented, and that the Hospital had achieved and maintained compliance. The inspection identified that the Hospital continued to be non-compliant with its patient care policies for effective patient supervision. In addition, the Department found that the Hospital failed to implement the directed plan of correction as required by the Department.

6. The results of the October 25, 2016 inspection set forth in the statement of deficient practice, a copy of which is attached hereto and made part hereof (Exhibit A), indicated that the Hospital is in violation of the civil provisions of R. I. Gen. Laws §§ 23-17-1 *et seq.* and the Rules and Regulations for Licensing Hospitals (R23-17-HOSP).

ORDER

After consideration of the above findings and a review of Department records that demonstrate the accuracy of the above findings, it is hereby ordered that:

The Hospital implement and complete the following actions within **15 calendar days** of receipt of this Order.

a. Review and update the Hospital's patient supervision policy to include:

i) Specific definitions for 1:1 patient supervision.

ii) Procedures for reporting and monitoring compliance with 1:1 supervision to the hospital's Quality Improvement Program/Committee.

iii) Procedures for referring non-compliant staff to their respective State Boards.

Implement routine monitoring of staff compliance with 1:1 patient supervision to include:

i) Monitoring to occur no less than 1 time per shift for every patient receiving 1:1 supervision.

ii) All monitoring will be conducted by non-union management staff.

iii) All completed monitoring will be documented and stored on file for Department review.

c. A status report shall be submitted to the Director of the Department regarding implementation of the above. This report shall be submitted no later than the 15th calendar day after receipt of this Order.

2. The Hospital implement and complete the following actions within **30 calendar days** of receipt of this Order.

a. Train all staff responsible for the ordering, monitoring and implementation of patient supervision to include:

i) A competency assessment for each staff member trained.

Successful completion of training documented in each staff member's personnel file.

Ongoing monthly progress reports, or as required more frequently by the Director of the Department, regarding the status and performance of the Hospital's compliance with this Order. Such reports are to be forwarded directly to the Rhode Island Department of Health, Center for

Health Facilities Regulation, 3 Capitol Hill, Room 306, Providence, RI 02908. The first report will be submitted no later than the 30th calendar day after receipt of this Order.

3. Notwithstanding any further findings, actions, or sanctions by the Department, this Order shall remain in effect until further notice. The Department shall forward a copy of this to the Office of the Attorney General, the Rhode Island Office of the Long Term Care Ombudsmen, and the State Medicaid Office.

Entered this 16 day of November 2016.

Ana Novais, MA
Executive Director
Rhode Island Department of Health

for
Nicole Alexander-Scott, M.D., M.P.H.
Director
Rhode Island Department of Health
Cannon Building, Room 401
Three Capitol Hill
Providence, RI 02903

A written request for a hearing may be filed with the Director of the Department within ten (10) days of this notice.

CERTIFICATION OF SERVICE

A copy of the within Compliance Order was delivered to the Hospital by the undersigned on this Sixteenth day of November, 2016 to _____.

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HOS00102	A. BUILDING: _____ B. WING _____	C 10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEANOR SLATER HOSPITAL	111 HOWARD AVE CRANSTON, RI 02921

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Z 0	INITIAL COMMENTS A state complaint investigation, A revisit to a previous complaint investigation, (*2BUN12, 10-25-16) and a federal complaint investigation (OIXI11, 10-25-16) were conducted at this hospital. Federal deficiencies were cited relative to the federal investigation and state deficiencies were cited relative to the state investigation and revisit.	Z 0		
Z 160	ORGANIZATION & MANAGEMENT 12.2 Organization 12.2 Each hospital department and service shall maintain: a) clearly written definitions of its organization, authority, responsibility and relationships; b) written patient care policies and procedures; and c) written provision for systematic evaluation of programs and services. This Requirement is not met as evidenced by: Based on surveyor observation, record review, staff interview, and review of hospital policy, it has been determined that the hospital continued to fail to implement it's policy for individual supervision for 1 of 5 sample patient's who are on individual supervision, patient ID# 16. Findings are as follows: A review of the hospital policy entitled, "Patient and Environment Safety and Monitoring Policy, Responsibility and Care of the Patient Requiring Individual Supervision" (June 2014) states, under procedures: 3. "Patients in need of "individual supervision at arm's length" are considered to pose a serious	Z 160		

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Z 160	Continued From page 1 risk of harm to self or others. A staff member must be in very close proximity (at arm's length) at all times to provide potential immediate intervention." Patient ID# 16 has diagnoses to include: severe developmental disabilities (MR) with autism, seizure disorder, and impulse control disorder with agitated/assualtive behavior. There is a physician's order, which is renewed daily, for 1:1 supervision in constant view and at arm's length when patient is seated for patient safety. There is a care plan for falls dated 8/25/2016 to current with an approach which requires a 1:1 supervision in constant view and at arm's length. The patient was observed on 10/7/2016 at 8:42 and 9:26 AM seated in a geriatric chair. A Nursing Assistant (staff G) was seated approximately 4 feet from the patient with an over the bed table in front of her. When interviewed on 10/7/2016 at 12:15 PM, staff G was unable to explain why she did not follow the physician's order. This issue was cited during the 12/1/2015 survey and was again identified as a violation during the 5/3/2016 survey. As a result, on 5/23/2016, the Department of Health issued a directed plan of correction. The hospital remains non-complaint with a component of the plan: A monthly monitoring program to evaluate continued compliance of staff with the 1:1 policy.	Z 160		
Z 210	ORGANIZATION & MANAGEMENT 13.8 Personnel	Z 210		

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Z 210	Continued From page 2 13.8 Pursuant to section 23-17-52 of the Rhode Island General Laws, as amended, any hospital licensed pursuant to Chapter 23-17 of the Rhode Island General Laws, as amended, shall provide to all patients and staff, through posted notices in conspicuous places throughout the hospital, the current Division of Facilities Regulation telephone number to call with concerns. Such notices shall be written in English and,at a minimum, the three most common languages used by patients served by each hospital as determined by such hospital, and shall include internationally-recognized symbol for sign language {including a relay number for access by hearing/speech impaired (TTY)}. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, it was determined that the hospital has failed to post the correct Department of Health (DOH) complaint phone number in a conspicuous place on the premises, in 3 most common languages used by patients, and include the nationally-recognized symbol for sign language. Findings are as follows: During all days of the survey, posting's including the DOH complaint phone number were observed throughout the hospital in all buildings on both campuses. The postings were typed in small font on 8 1/2 by 11 inch paper, framed and, when measured on 10/17/2016, hung approximately 55 inches off the ground to the bottom of the frame (not accessible to patients in wheelchairs), not in the 3 most common languages used by the patients, and did not include the nationally-recognized symbol for sign language. Additionally, the telephone number to the DOH complaint line is incorrect.	Z 210		

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Z 210	Continued From page 3 When interviewed on 10/7/2016 at 1:20 PM, the Director of Social Services was unable to explain why the DOH information was not properly posted.	Z 210		
Z 216	ORGANIZATION & MANAGMENT 13.11 Safe Patient Handling Safe Patient Handling 13.11 Each licensed hospital shall comply with the following as a condition of licensure: a) Each licensed hospital shall establish a safe patient handling committee, which shall be chaired by a professional nurse or other appropriate licensed health care professional. A hospital may utilize any appropriately configured committee to perform the responsibilities of this section. At least half of the members of the committee shall be hourly, non-managerial employees who provide direct patient care. b) Each licensed hospital shall develop a written safe patient handling program, with input from the safe patient handling committee, to prevent musculoskeletal disorders among health care workers and injuries to patients. As part of this program, each licensed health care facility shall: (i) Implement a safe patient handling policy for all shifts and units of the facility that will achieve the maximum reasonable reduction of manual lifting, transferring, and repositioning of all or most of a patient's weight, except in emergency, life-threatening, or otherwise exceptional circumstances;	Z 216		

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Z 216	Continued From page 4 (ii) Conduct a patient handling hazard assessment. This assessment should consider such variables as patient-handling tasks, types of nursing units, patient populations, and the physical environment of patient care areas; (iii) Develop a process to identify the appropriate use of the safe patient handling policy based on the patient's physical and mental condition, the patient's choice, and the availability of lifting equipment or lift teams. The policy shall include a means to address circumstances under which it would be medically contraindicated to use lifting or transfer aids or assistive devices for particular patients; (iv) Designate and train a registered nurse or other appropriate licensed health care professional to serve as an expert resource, and train all clinical staff on safe patient handling policies, equipment, and devices before implementation, and at least annually or as changes are made to the safe patient handling policies, equipment and/or devices being used; (v) Conduct an annual performance evaluation of the safe patient handling with the results of the evaluation reported to the safe patient handling committee or other appropriately designated committee. The evaluation shall determine the extent to which implementation of the program has resulted in a reduction in musculoskeletal disorder claims and days of lost work attributable to musculoskeletal disorder caused by patient handling, and include recommendations to increase the program's effectiveness; and (vi) Submit an annual report to the safe patient handling committee of the facility, which shall be	Z 216		

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Z 216	Continued From page 5 made available to the public upon request, on activities related to the identification, assessment, development, and evaluation of strategies to control risk of injury to patients, nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a patient. c) Nothing in this section precludes lift team members from performing other duties as assigned during their shift. d) An employee may, in accordance with established facility protocols, report to the committee, as soon as possible, after being required to perform a patient handling activity that he/she believes in good faith exposed the patient and/or employee to an unacceptable risk of injury. Such employee reporting shall not be cause for discipline or be subject to other adverse consequences by his/her employer. These reportable incidents shall be included in the facility's annual performance evaluation. This Requirement is not met as evidenced by: Based on record review and staff interview, it was determined that the hospital failed to implement the safe patient handling protocol for patient ID # 1. Findings are as follows: Patient ID# 1 is immobile. The "Admission Safe Patient Handling and Assessment Tool" for this patient, dated 2/1/2016, documents the need for 2 staff members for bed bath/showering. On 9/13/2016 this resident sustained injuries to both feet in the form of abrasions to several toes. The	Z 216		

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Z 216	Continued From page 6 resident was being showered by only one nursing assistant (NA) at the time the injury occurred. The unit nurse (staff C) was interviewed on 10/5/2016 at 11:15 AM. Although the schedule showed that two NA's were assigned to the patient on 9/13/2016, staff C told the surveyor that the usual routine is for one NA to provide the shower to a patient while the second NA changes the bed and cleans up in the patient's room, i.e. only one staff member accompanies the patient to the shower room and provides the shower, which is contrary to the safe patient handling assessment and plan.	Z 216		
Z 350	PATIENT CARE SERVICES 19.2 Patient Care Management 19.2 There shall be evidence that medical, nursing and other services are provided under an integrated written plan of care for each patient. Written care plans shall identify problems, goals, and interventions. Goals shall be measurable. This Requirement is not met as evidenced by: Based on surveyor observation, record review and staff interview, it was determined that the hospital continues to fail to provide care for 2 patients in accordance with a written plan of care for 1 of 5 patients (ID# 1) relative to safe patient handling and for 1 of 5 patients (ID# 16) relative to constant supervision. Findings are as follows: 1. Patient ID # 1 lacks mobility. The patient care plan dated, 8/19/2016 to current, specifies, "2 CNA's provide total care w/ADL's (activities of daily living) per hospital P&P (policies and	Z 350		

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Z 350	Continued From page 7 procedures)". On 9/13/2016 this resident sustained injuries to both feet in the form of abrasions to several toes. The resident was being showered by only one CNA at the time the injury occurred. The nurse (staff C) was interviewed by the surveyor on 10/5/2016 at 11:15 AM. Although the schedule showed that two CNA's were assigned to the patient on 9/13/2016, staff C told the surveyor that the usual routine is for one CNA to provide the shower to a patient while the second CNA changes the bed and cleans up in the patient's room. The staff member reported that this is the situation that existed at the time of the injury on 9/13/2016. On 10/20/2016, between 11:00 AM and noon, three additional nursing staff were interviewed regarding showering procedures for totally dependent patients. Staff A told the surveyor that this patient, "should have been a two person assist. I don't know why the second aide was not in there." Staff D told the surveyor, "Anyone who is non-verbal should be a two-person assist at all times." Staff E told the surveyor that, "the number of staff assisting with the shower depends on the safe handling assessment". On 10/21/2016, the policy & procedure for showering dependent patients was requested by a surveyor. The Nurse Manager (staff F) told the surveyor that there is no written procedure, but that the hospital policy is to have two staff members present for bathing/personal care. 2) Patient ID# 16 has diagnoses to include: severe developmental disabilities (MR) with autism, seizure disorder, and impulse control disorder with agitated/assualtive behavior.	Z 350		

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Z 350	Continued From page 8 There is a physician's order, which is renewed daily, for 1:1 supervision in constant view and at arm's length when patient is seated for patient safety. There is a care plan for falls dated 8/25/2016 to current with an approach which requires a 1:1 supervision in constant view and at arm's length. The patient was observed on 10/7/2016 at 8:42 and 9:26 AM seated in a geriatric chair. A Nursing Assistant (staff G) was seated approximately 4 feet from the patient with an over the bed table in front of her. When interviewed on 10/7/2016 at 12:15 PM, staff G was unable to explain why she did not follow the plan of care.	Z 350		
Z 375	PATIENT CARE SERVICES 19.7 Patient Care Management 19.7 Medical Restraints: In acute medical and pre/post-surgical care, a patient shall be free from physical and chemical restraint that is not medically necessary. A restraint shall only be used if needed to improve the patient's well-being and only if less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. Behavioral Restraints: A patient shall be free from seclusion or restraint imposed as a means of coercion, discipline, convenience or retaliation by staff. Seclusion or restraint employed for behavior management shall only be used in emergency situations if needed to ensure the patient's or other's physical safety and less restrictive interventions have been determined to be ineffective.	Z 375		

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Z 375	Continued From page 9 19.7.1 Restraints/seclusion use shall be prescribed in writing and signed by a physician or other licensed practitioner acting within his/her scope of practice and permitted by the hospital to order restraints/seclusion. The type and duration of restraints/seclusion shall be specified. Standing or "on an as needed basis" (i.e., PRN) orders shall not be permitted. 19.7.2 Restraints/seclusion, if used, shall be addressed in the written treatment plan for the patient. 19.7.3 Restraints/seclusion use shall be based on an assessment of the patient, implemented in the least restrictive manner possible, implemented in accordance with safe and appropriate restraining techniques, and discontinued at the earliest possible time. 19.7.4 The condition of a restrained/secluded patient shall be continually assessed, monitored, and reevaluated. This Requirement is not met as evidenced by: Based on surveyor observations, record review and staff interview, it has been determined that the hospital failed to obtain an order for a restraint from a physician or other licensed practitioner acting within his/her scope of practice for 4 of 4 sample patients (ID #16, 41, 42, & 43) who are in restraints. Findings are as follows: 1. Patient ID# 16 has diagnoses to include: severe developmental disabilities (MR) with autism, seizure disorder, and impulse control disorder with agitated/assualtive behavior. Record review revealed physician's orders dated 10/13/2016, under the fall reduction protocol, for a Craigs bed (a bed with 4 foot padded sides to	Z 375		

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Z 375	Continued From page 10 prevent egress and with a door that opens from the outside) and posey lap belt with crotch strap when in chair for fall prevention. Additionally, there is an order for a 1 piece suit to be worn to prevent disrobing. The patient was observed on 10/7/2016 at 8:42 AM, 10/20/2016 at 11:45 AM, and on 10/21/2016 at 12:45 PM reclined in a geriatric chair wearing a 1 piece suit, with a zipper in the back. The patient was also secured to the chair with a pelvic posey surrounding the patient's hips, which is secured from the back of the chair. The patient cannot remove either the 1 piece suit or the posey. Additionally, on 10/20/2016 at 9:40 AM, the patient was observed sleeping in the Craigs bed. The patient's physician was interviewed on 10/20/2016 at 1:30 PM relative to the above orders. She stated that the patient frequently has hallucinations/psychotic events with self injurious behaviors such as head banging and thrashing of the limbs. The Craigs bed keeps the patient safe during these events. Additionally, the patient enjoys the bed and becomes combative when placed into a regular bed. The pelvic posey is utilized to keep the patient safe as he/she tends to thrash when in the chair. The 1 piece suit is utilized as, in the past, the patient has removed his brief and smeared the contents. 2. Patient ID# 41 has diagnoses to include: history of muscular dystrophy with secondary incomplete quadriplegia, lower leg contractures, severe cognitive & language deficits. Record review revealed physician's orders dated 10/11/2016, under the fall reduction protocol for a	Z 375		

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Z 375	Continued From page 11 Craigs bed. The patient's room was observed on 10/20/2016 at 11:00 AM and revealed a Craigs bed. The patient's physician was interviewed on 10/20/2016 at 10:40 AM relative to the Craigs bed. She stated that the patient lived with the mother and basically lived on floor mats where he/she was able to crawl around the house. They attempted to put the patient in a regular bed, but he/she just crawled out and was found crawling down the hall. They feared for the patient's safety. The padded walls of the bed are necessary to prevent injury during head banging behaviors. 3. Patient ID# 42 has diagnoses to include: frontal lobe dementia, anxiety/behavior disorder. Record review revealed physician's orders dated 10/4/2016, for hand mitts when the patient is observed to punch hard objects (TV, window, chair, table, etc) and a one piece suit for infection control purposes (pt smearing feces on his/her head). Observations of the patient on 10/21/2016 at 9:10 AM, 11:35 AM, and 1:30 PM revealed the patient walking up and down the halls in a one piece suit. The patient's physician was interviewed on 10/20/2016 at 10:40 AM relative to the hand mitts. She stated that the patient walks up and down the halls banging hard objects. To prevent him/her from injury, hand mitts are applied to his/her hands and removed when the behavior stops. The one piece suit is for infection control. 4. Patient ID# 43 has diagnoses to include:	Z 375		

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	HOS00102	A. BUILDING: _____ B. WING _____	C 10/25/2016

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Z 375	Continued From page 12 dementia of the Alzheimer's type and behavior disorder. Record review revealed physician's orders dated 10/12/2016, for roll belt when in bed and a padded posey lap belt when in chair for fall prevention. Observation of the patient on 10/21/2016 at 1:30 PM revealed the patient sitting in a geriatric with a padded posey lap belt in place. The nurse (staff C) was interviewed at this time and stated that the posey is utilized for this patient because he/she cannot understand his/her physical limitations. The roll belt is also utilized so that he/she cannot roll out of bed. Although the above interventions are appropriate for these patient's, there is no evidence that they are ordered as restraints or continually assessed, monitored, and reevaluated.	Z 375		
Z1725	ENVIRONMENTAL & MAINTENANCE SERVICES 51.1 Infection Control Section 51.0 Infection Control 51.1 The medical staff in cooperation with other disciplines shall establish a multidisciplinary group which shall report to the governing body and which shall be responsible for no less than the following: a) establishing and maintaining a hospital-wide infection surveillance program which shall include an infection surveillance officer to conduct all infection surveillance activities; b) developing and implementing written policies and procedures for the surveillance, prevention,	Z1725		

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Z1725	Continued From page 13 and control of infections in all patient care departments/services; c) establishing policies governing the admission and isolation of patients with known or suspected infectious diseases; d) developing, evaluating and revising on a continuing basis infection control policies, procedures and techniques for all appropriate phases of hospital operation and services; e) developing and implementing a system for evaluating and recording the occurrences of all infections among personnel and patients; such records shall be made available to the licensing agency upon request; f) implementing a TB infection control program requiring risk assessment and development of a TB infection control plan; early identification, treatment and isolation of strongly suspected or confirmed infectious TB patients; effective engineering controls; an appropriate respiratory protection program; health care worker TB training, education, counseling and screening; and evaluation of the program's effectiveness, per guidelines in reference 33. g) developing and implementing an institution-specific strategic plan for the prevention and control of vancomycin resistance, with a special focus on vancomycin-resistant enterococci, per guidelines in reference 50. h) developing and implementing protocols for discharge planning of patients with infectious diseases which may present the risk of continuing transmission in thecommunity or congregate living environment. Examples of such diseases include, but are not limited to, tuberculosis (TB), Methicillin resistant staphylococcus aureus (MRSA), clostridium difficile, etc. i) assuring that patient care support departments (i.e., central services, laundry, etc) are available	Z1725		

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Z1725	Continued From page 14 to assist in the prevention and control of infectious diseases and are provided with adequate direction, training, staffing and facilities to perform all required infection surveillance, prevention and control functions. This Requirement is not met as evidenced by: Based on surveyor observation, record review and staff interview it has been determined that the hospital continued to fail to implement the procedures pertaining to personal protective equipment in accordance with their Infection Policy and Procedure for 1 of 2 sample patients (ID #15). Findings are as follows: Review of the hospital policy entitled, "Eleanor Slater Hospital Infection Prevention and Control Department" revealed under Transmission Based Precautions "Droplet Precautions (droplets that can be generated by the patient during coughing, sneezing, talking, or performance of procedure)... Wear a mask when working within 3 feet of the patient... Wear a gown when entering the room... Wear gloves when entering the room..." On 10/6/2016 at 10:55 AM, the surveyor observed patient ID #15 lying in the recliner chair in his/her room. The surveyor observed a unit nurse (staff H) enter the patient's room without doning a gown, gloves, and mask and obtained the patient's temperature. A sign outside the patient's room revealed the	Z1725		

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Z1725	Continued From page 15 patient is on Level 3 Droplet Precautions. Review of the patient's medical record revealed, Level 3 Droplet Precautions. A 9/20/2016 laboratory result indicates he/she is positive for (Extended-Spectrum Beta-Lactamase) in his/her sputum. When interviewed on 10/6/2016 at 11:20 AM, the charge nurse (staff I) revealed the patient is on Level 3 Droplet Precautions which means staff must done a gown, gloves and mask when entering the patient room. The issue of staff not following the hospital policy and procedure was identified during the survey on 5/3/2016. The plan of correction dated 5/2016 indicates "The 2016 Annual Infection Prevention and Control In-service was completed in May, 2016. It is mandated for all employees." A review of the Infection Prevention and Control In-Service log and interview with the nurse manager (staff F) on 10/7/2016 at 10:30 AM and staff H on 10/7/2016 at 11:20 AM failed to reveal he had received the mandatory in-service according to the hospital plan of care. During interview with the Risk Manager (staff B) on 10/18/2016 at approximately 11:00 AM, she stated staff must wear a gown, gloves and mask when entering the patient's room according to the hospital policy and procedure. The hospital continues to fail to implement procedures relative to infection prevention and control.	Z1725		